Before the
Federal Communication Commission
Washington, D.C. 20554

In the Matter of)
)
Rural Health Care Support Mechanism) WC Docket No. 02-60

Reply Comments

USF Consultants responds to the August 9th, 2010 Public Notice by the Federal Communication Commission seeking comment to expand the Rural Health Care Program.

Level of Support "health broadband services program"

I totally endorse the introduction of the Health Broadband Services Program to allow funding of point to point circuits at a flat rate of 50%. The HBSP with the current Telecommunication Program (TP) will allow Health Care Providers the most flexibility in seeking funding support.

Options are good; however, the founding principle of the Universal Service Fund for Rural Health Care Urban verses Rural difference. "Competition will come to Urban Areas and Rural Areas will have fewer options as to service and the cost of those services will be higher. The Universal Service Fund will level the playing field."

Competition did come to the Urban Mass Markets, Prices for Telecommunication Services of all types in Urban Markets plummeted, and Rural Areas continue to have Limited Services and Few Choices. And the issue of Few Choices does remind me of the few choices USAC provides as default Urban Rate amounts. The rates that are presented (tariff list price) do not reflect the true negotiated cost of services in the Urban Mass Market. The lack of true Urban Rates results in less support to Health Care Providers (HCP) for each and every service.

The State of Alaska has come up with a matrix of various services and speeds for all kinds of voice and data services including 10M/20M/50M/100M/1G service. I also noted in the pretty picture section Alaska is the top state in funding $$$. Is there a connection between having easily available rates for all categories of services and the states success in receiving funding?

I urge the Federal Communication Commission invest additional resources to allow all Health Care Providers (HCP) using the Telecommunication Program access to relevant Urban Rates for voice services and non broadband data services. A recent study indicated a lot of hospitals use telephone service and that service ain't cheap.

Definition of Rural Areas

With the 2010 census just completed, I request the FCC to revisit the definition of rural. As with the case of high bandwidth services, often to meet the needs of the program participants, there needs to

be 2 methods. The telecommunication program and the health broadband services program will provide support for the same services but based on a slightly different perspective.

The same perspective must be provided to the determination eligibility of health care program participants. The addition of the US Department of Agriculture Business and Industry Definition:

> Eligible Areas: areas outside the boundaries of a city or town of more than 50,000 in population and urbanized area contiguous and adjacent to such city or town.

This definition would allow for locations that are currently not eligible based on urban-rural commuting and census track anomalies which have small towns (population less than 5,000) surrounded by rural areas appear to be an urban area.

The use Department of Agriculture would result in approximately 36% of the population located in eligible rural locations.

Infrastructure Build-out

More than ever, I believe infrastructure build-out must be coordinated by not a hospital or consortium of hospitals but must fall under state managed oversight. The elements of the Universal Service Program, Rural Health Care, Schools and Libraries and High Cost along with additional funding from Rural Broadband must be coordinated.

The $100M for Rural Health Care Infrastructure Build-out is dwarfed by the Schools and Libraries $2B budget and the High Cost $4B budget. The high bandwidth high availability health networks of the future will be in most part hybrid. Intercity transport may best be served by the use of High Cost Funding with Rural Health Care Funding providing the last mile service. Sharing facilities and costs with the Schools and Libraries Program can provide additional savings and improved access in rural areas.

Hospitals are not equipped with the task of building and coordinating telecommunication facilities. It just so happens, the staff and administration of hospitals do an excellent job of treating medical conditions. Network build-out on public lands needs to have specialists to manage the project.

An effort of this magnitude will require coordination with all stakeholders involved in the process and be able to fairly and accurately determine the best investment strategy. Input from carriers, health care providers, local government, and other participants must be reviewed and coordinated.

Each state has the resources within their departments to accomplish this monumental task. With the state taking the lead, there is accountability, transparency, effective project management and builds on a base of existing knowledge.

Details of Infrastructure Process

We strongly agree the **Program Process** be streamlined to speed both the initial application and the project selection. The general timelines taking place each year between July –Dec (6 months) provides adequate time to address the worthiness of each project **Project Selection Phase.**

With $100 Million available each year in the Infrastructure program, a major issue will be cash flow per year. The initial infrastructure funding year should focus on projects which can be completed in a short amount of time and provide significant benefit based on accessing bandwidth to rural health care provider locations. Areas designated as Medically Underserved should have a slight preference based on the project utilizing telehealth technology to meet the health care shortage.

The maximum number of projects does not need cap, but a single project should not exceed $10 million dollars total or $5 million dollars per year (2 yr max).

Prior to the **Project Selection Phase,** information must be provided that the project is viable from a funding standpoint (15% provided outside the fund), the project milestones and estimated start/completion dates. This will allow several small projects to begin with accelerated completion dates. Larger projects can also be selected with staggered/later start dates to work within the allocated budget. Additional projects should be on await list should the final documentation in the **Project Commitment Phase** fails to meet the minimum requirements within 90 days of selection.

There are 12 key items to be addressed in the **Project Commitment Phase**

15% Financial Commitment	Project Milestones	Project Description
Facilities Ownership	Standard Terms and Conditions	Sustainability Plan
Excess Capacity	Vendor Cost Reporting	Quarterly Reports
Competitive Bidding	Completion of Project	NEPA NHPA

I'll comment on just a few of the items:

<u>15% Financial Commitment & Additional Financial Commitment</u> represents over the life of the project (15 years) a cost of only 1 % of the value of the service per year. The hospital pays only 1%. With the hospital paying only 1% of the true cost of the service there is no need to create a profit center using excess capacity and ownership should be in placed in the hands of the state to benefit all rural areas.

However, there will be up-front costs that are not covered by the program and those costs must be detailed in the project plan and a source of funding documented for those costs along with the estimated 15% contribution of the covered costs.

<u>Facilities Ownership</u> should be designated at all time as being owned by the people (state) since the people are paying for the facilities

<u>Excess Capacity</u> under state ownership would not be an issue. Hospitals should not be involved with using facilities to bypass the regulated telephone companies forcing higher local charges for facilities. By combining the needs of the rural health program, schools and libraries program, and the high cost program together; the facilities installed (the cost) would be shared by more program participants.
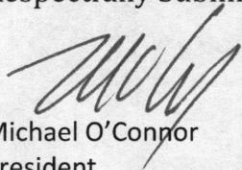
<u>Project Description/Milestones</u> are critical not only for the project under construction but also for future construction projects. Milestones and timeline are important and USAC should have in place a review team to verify milestones, payments to vendors, and also have field audits to confirm the validity of the project.

Build-out Period should be limited to cover only a period of 2 funding years and be completed no more than 3 years after receipt of the first FCL. If projects are of such a nature to require more than 3 years, the projects should be broken into smaller projects.

Demonstrated Need for Infrastructure Funding it very well covered in the NTIA as they have contracted with an organization in each state to create and update the broadband maps. For Wisconsin, that would be the Public Service Commission.

Bandwidth should be initially operational at 10-20M at small clinics with the ability to increase to 100M as needed. The benchmark for all locations should be 100M with regional/state centers having 1G minimum.

Respectfully Submitted,

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September 23, 2010